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MALE-TO-FEMALE TRANSGENDER VETERANS AND VA HEALTH CARE UTILIZATION

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ABSTRACT. This study examined rates of military veteran status in an American male-to-female transgender community sample ($n = 141$). Thirty percent were veterans ($n = 43$), a rate that is triple the proportion of veteran status noted in the general population (10.1%). Among the veteran subsample, we examined health care utilization, including Veterans Health Administration (VA), health, and barriers to care. Use of VA services was higher among transgender veterans (transvets) than published rates of VA use in the general population of veterans (annual 6.2% to 15.8%), with 16.3% of all transvets seeking some VA care in the past 6-months. The most common physical health problems treated at the VA in the past year were high cholesterol, blood pressure, and vision problems. Irrespective of VA use, the majority of transvets reported getting routine health care (88.4%), and their physical health ratings were commensurate with population norms. Mental health services (e.g., depression, posttraumatic stress disorder, and gender identity counseling) were also utilized (9.3% VA, 25.6% non-VA) at levels consistent with the relatively low mental health functioning scores in this sample (SF-12 = 32.6, *SD* = 8.3). Barriers to care were endorsed more for medical than mental health treatment. In particular, transvets were concerned about medical providers' reactions to their gender identity or sexual orientation. Given elevated rates of transvets in this community sample and reported barriers to care, culturally sensitive treatment is a priority for transvets in both VA and non-VA health care systems.

KEYWORDS. Transgender, transsexual, gender, veteran, service utilization, barriers to care

Transgender is an umbrella term used for individuals whose self-identified gender does not match their sex assigned at birth (Maguen, Shipherd, & Harris, 2005). Reports and clinical observations suggest that rates of veteran status among transgender populations may be elevated (Brown, 1988; Brown & Rounsley, 1996; Transgender American Veterans Association [TAVA], 2008). National news reports also suggest that the veteran rate among transgender populations is higher than in the general public (Alaimo, 2009a). For example, clinicians specializing in transgender care stated that more than half of the male-to-female transgender (MtF) patients in their practice had served in the military. These patients appear to have served honorably and had long and reputable military careers (Brown & Rounsley, 1996). However, the U.S. Census Bureau does not evaluate transgender status, making further work necessary to clarify rates of veteran status in the transgender community.

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The U.S. Census Bureau estimated the rate of veteran status among the general population to be 10.1% in 2009 (U.S. Census Bureau, 2011), which provides a context for understanding rates of veteran status in specialized groups. Unfortunately, it is difficult to estimate the rate of transgender individuals in both general and military populations given the social stigma associated with transgender identity; these include risks to military affiliation, impact on service connection (disability payments), the potential risk for harassment, and discrimination and/or violence (e.g., Shipherd, Maguen, Skidmore, & Abramovitz, 2011). To our knowledge, no studies of the transgender population have examined rates of veteran status.

Theoretical conceptualizations have been developed to explain elevated rates of veteran status in the transgender community. Given the military's clear cultural norms about appropriate behavioral expressions of masculinity and femininity, these theories highlight developmental factors that could influence decisions to join the military, particularly for MtF individuals (Brown, 1988; Devor, 2004). For example, Devor's identity confusion stage of transsexual development includes attempts to repress gender questioning and occurs in late adolescence, when joining the military is common (Brown, 1988; Devor, 2004). Thus, as young MtF transgender people seek to inhibit gender questioning during the identity confusion stage, the military environment provides an atmosphere that assists in asserting stereotypical masculine traits, which has been termed "flight into hypermasculinity" (Brown, 1988, p. 527). In addition to more general reasons for joining the military such as patriotism, career goals, and/or benefit packages, this theory provides a transgender-specific motivation for enlisting. In support of this theory, a recent chart review of 70 American transgender veterans (transvets) and active duty military personnel treated for gender identity issues found that the majority endorsed a "flight into hypermasculinity" (McDuffie & Brown, 2010). Thus, theoretical conceptualization and published reports support the hypothesis that there would be elevated rates of veteran status within the transgender community.

In addition to evaluating the rates of veteran status, patterns of health care utilization and barriers to seeking services within the transgender community also need examination. In particular, understanding transvets' use of U.S. Veterans Health Administration (VA) services is a timely issue given that in June 2011, the VA passed a nationwide policy that assures access to care for transvets (Department of Veterans' Affairs, 2011). This groundbreaking policy provides transvets and VA providers with clarity about access to VA for services such as mental health care, hormonal therapy, preoperative evaluations, and medically necessary postoperative and long-term care following sex reassignment surgery. Further, the policy begins to introduce appropriate cultural-care issues, such as correct pronoun use and room assignments. Thus, it is possible that there will be an increase in VA use among transvets following the passage of this policy. An increase in VA use would also be consistent with the national trend of VA use being on the rise (Long, Polsky, & Metlay, 2005), although a minority of all veterans use VA health care.

The range of VA health care utilization in the general veteran population is between 6.2% and 15.8%, depending on the study, timeframe assessed, and the amount of VA use included (Ashton, Peterson, Wray, & Yu, 1998; Long et al., 2005; Nelson, Starkebaum, & Reiber, 2007). Previous research in the general population into factors that predict VA use suggest that VA facilities are meeting their mission of providing care to individuals who have served our country but who cannot afford to obtain health care elsewhere (Long et al., 2005). Across studies, those who did *not* receive health care at the VA in the past year were more likely to be covered by private insurance, could afford to pay for private health care visits, were Caucasian, had higher education, were less likely to have health problems, and were less likely to have visited a physician at all in the past year as compared with VA users (Ashton et al., 1998; Long et al., 2005; Nelson et al., 2007). This suggests that even if rates of veteran status are elevated

in the transgender community, this would not necessarily translate into a similar proportion of transvets who use VA services as there are individual difference characteristics (e.g., health problems) that can influence VA usage.

There is some evidence to suggest that transvets are currently using VA services. A recent newspaper series reported that the Southern Arizona VA treated 50 transvets (Alaimo, 2009b), and a national survey of 827 transvets conducted by a transgender veteran advocacy group found that 29% were currently using the VA for health care and 38% had ever used the VA (TAVA, 2008). These reported rates are much higher than among the general veteran population (Ashton et al., 1998; Long et al., 2005; Nelson et al., 2007). Similar to studies of VA utilization in the general population, transvets who used the VA were more likely to be older and not working compared with non-VA users (TAVA, 2008).

In light of the new VA policy assuring access to services for transvets, it is essential to understand current patterns of utilization. If transvets are not using the VA regularly, understanding barriers to service utilization is essential, as is knowing if transvets are avoiding preventative care altogether. Alternatively, it is possible that VA-eligible transvets are seeking care at other trans-friendly health care clinics via private insurance or other means, which would have different implications for later VA use. Thus, the purpose of this study was to examine: (1) rates of veteran status in a sample from the transgender community; 2) VA and non-VA health care utilization among the transvet subsample; and 3) barriers to health care service utilization (both at the VA and in general).

METHOD

Participants

The sample consisted of 141 self-identified MtF transgender individuals who were recruited from a social and informational transgender conference held in a suburb of Boston, MA in 2008. Participants ranged in age from 26 to 79 years old ($M = 51.6$, $SD = 10.9$). They identified as MtF transsexual[1] ($n = 80$) or MtF cross-dresser ($n = 61$) and primarily identified as Caucasian ($n = 136$). In addition, the majority of the sample was employed ($n = 104$), while others were retired ($n = 20$), unemployed ($n = 12$), disabled ($n = 2$), or students ($n = 2$). One participant did not report their employment status. The sample was highly educated, with 85 participants having obtained a bachelor's degree or higher.

Procedure

As part of a larger study (Shipherd, Green, & Abramovitz, 2010; Shipherd et al., 2011), anonymous survey packets were distributed and completed at a table in the vendor area of the conference hotel, as approved by the VA Boston Institutional Review Board.

Measures

Demographics

Demographic characteristics assessed in the survey included gender identity, age, education, employment, and military service.

Health care benefits and insurance status

Participants were asked about type of primary health care insurance (through employer, through a family member, Medicare, Medicaid, student health, or VA) and eligibility for health care at the VA (yes, no, not sure).

Health care utilization (VA and non-VA)

Types of health care utilization in the past year and time since last doctor visit (never; 6 months or less; or more than 6 months, 1 year, 2 years, or 5 years ago) were evaluated.

[1]According to *VHA Directive 2011–024: Providing Health Care for Transgender and Intersex Veterans* (Department of Veterans' Affairs, 2011): "Male-to-female (MtF) transsexuals are individuals who are male sex at birth, but self-identify as female and often take steps to socially or medically transition to female, including feminizing hormone therapy, electrolysis, and surgeries (e.g., vaginoplasty, breast augmentation)" (p. 1).

VA and non-VA health care utilization were assessed separately in terms of the number of visits in the past year for each particular type of care (routine care, sick visits, specialist care, emergency room visits, surgeries, and mental health visits). In addition, a list of common physical and mental health problems were rated in a yes/no response format indicating if participants received treatment for those conditions in the past year, with an additional item indicating if care occurred at the VA (yes/no).

Physical and mental health functioning

The 12-Item Short-Form Health Survey (SF-12; Ware, Kosinski, & Keller, 1996) is a 12-item questionnaire used to assess general physical and mental health functioning. Two composite *t*-scores were calculated via the weighted algorithm specified in the scoring manual (Ware, Kosinski, & Keller, 1995) for physical and mental health functioning. Each composite score was based on responses to 6 items about perceived mental or physical health functioning. In the general population, the composite scores have a mean of 50, a standard deviation of 10, and a range from 0 (worst health) to 100 (best health). The SF-12 has good divergent validity discriminating between patients with serious and minor physical health problems as well as clinical depression and is highly convergent with the well-validated 36-Item Short-Form Health Survey (Ware et al., 1996).

Barriers to VA use

Overall extent of VA use in the past 6 months was assessed with a single item (all, some, or no VA care). Those participants who did not receive services from the VA in the past 6 months were asked to select a reason from the following six choices: not eligible for VA care, not using any care in the past 6 months, dislike of VA atmosphere, concern about discrimination, dislike of VA doctors, and inconvenience of VA locations.

General barriers to health care utilization

The *Service Utilization Barriers Scale* (SUBS; Shipherd et al., 2010) evaluated perceived barriers to seeking health care more generally. Participants rated 46 potential barriers on a 5-point Likert scale from "strongly disagree" to "strongly agree." Each item was rated separately for mental health and for medical health services, and items were phrased as thoughts and beliefs (e.g., "I would be less accepted by friends"). For the purposes of this study, items were considered barriers only when rated "agree" or "strongly agree."

RESULTS

Rates of Veteran Status

Thirty percent of the participants ($n = 43$) had served in the Armed Forces including all branches of the military: Army ($n = 20$), Air Force ($n = 11$), Navy ($n = 6$), Marines ($n = 3$), National Guard ($n = 5$), Reserves ($n = 8$), and Coast Guard ($n = 2$), with 12 individuals serving in more than one organization. The demographic characteristics of transvets mirrored those of the larger sample, although transvets were slightly older at 58 years ($SD = 12.3$; range 26–79 years). Roughly half the transvets identified as MtF cross-dressers ($n = 22$) and half identified as MtF transsexuals ($n = 21$). Twenty-three participants were employed full time, 13 were retired, 3 were employed part time, 2 were unemployed, 1 was disabled, and 1 was a student.

Health Care Benefits and Insurance Status of Transgender Veterans

The majority of transvets were insured, with only 2 individuals not having insurance. Insurance coverage was through their employer ($n = 23$), Medicare ($n = 14$), family member ($n = 4$), Medicaid ($n = 1$), or student health programs ($n = 1$). Among transvets, about half ($n = 23$) reported being eligible for VA services, 11 believed they were not eligible, and 9 were not

TABLE 1. Past Year Use of VA and Non-VA Services Reported by Transgender Veterans

	Location of Treatment	
Type of Care	VA *n* (%)	Non-VA *n* (%)
Primary care provider for a sick visit	4 (9.3%)	10 (22.3%)
Preventative and routine care	3 (7.0%)	33 (76.7%)
Mental health visits	4 (9.3%)	11 (25.6%)
Medical specialist	3 (7.0%)	22 (51.2%)
Hospital emergency room	0	3 (7.0%)
Surgical visits (outpatient or inpatient)	1 (2.3%)	4 (9.3%)

sure if they were eligible for VA services. Four individuals reported using VA benefits as their primary health insurance (9% of transvets).

Health Care Utilization (VA and non-VA)

Irrespective of VA use, the majority of transvets reported a recent health care visit, with 88.4% ($n = 38$) reporting a visit within the past year. A minority ($n = 5$) indicated that it had been more than 1 year since their last doctor's visit. Table 1 displays the types of utilization at VA and non-VA facilities in the past year, with the most common visits across facilities being for preventive/routine care ($n = 36$) and for medical specialists ($n = 25$). Rates of mental health visits ($n = 15$) were comparable to sick visits ($n = 14$). Participants reported a range of physical health for which they received treatment in VA and non-VA facilities (see Table 2), with the most common being visits for high cholesterol ($n = 24$), vision problems ($n = 23$), and blood pressure ($n = 22$). Similarly, a variety of mental health conditions were treated at VA and non-VA facilities, including gender identity counseling ($n = 19$), relationship problems ($n = 6$), and depression ($n = 5$; see Table 3). Gender identity counseling was more likely to be sought at non-VA facilities than at VA facilities ($z = 4.28$; CI = 99%).

Physical and Mental Health Functioning

The physical health functioning score on the SF-12 among transvets was 49.8 ($SD = 5.0$), indicating physical health comparable to that of the general population (Ware et al., 1995). In contrast, the mental health composite score was lower than general population scores at 32.6 ($SD = 8.3$). Given that mental health functioning was nearly 2 standard deviations below the general population mean (50, $SD = 10$), the remaining nonveteran participants with data for this measure ($n = 116$) were examined on this variable. The composite score for mental health functioning for the nonveteran transgender participants was 34.6 ($SD = 8.1$), suggesting that greater mental health problems were characteristic of our sample and not specific to veteran status.

TABLE 2. Type of Physical Health Conditions Treated in the Past Year Among Transgender Veterans

	Location of Treatment	
Physical Health Condition	VA *N* (%)	Non-VA *N* (%)
High cholesterol	5 (11.6%)	19 (44.2%)
Blood pressure	4 (9.3%)	18 (41.9%)
Vision problems	2 (4.7%)	21 (48.8%)
Chronic pain	1 (2.3%)	5 (11.6%)
Arthritis	1 (2.3%)	2 (4.7%)
Digestive problems	1 (2.3%)	2 (4.7%)
Cancer (any type)	0	4 (9.3%)
Hearing	0	3 (7.0%)
Lung problems	0	2 (4.7%)
Kidney problems	0	1 (2.3%)
Diabetes	0	1 (2.3%)

Barriers to VA Use

Among transvets who believed that they were eligible for VA services ($n = 23$), 7 (30%)

TABLE 3. Type of Mental Health Conditions Treated in the Past Year Among Transgender Veterans

	Location of Treatment	
Mental Health Condition	VA *n* (%)	Non-VA *n* (%)
Depression	2 (4.7%)	3 (7.0%)
Posttraumatic stress disorder	2 (4.7%)	0
Gender identity counseling	2 (4.7%)	17 (39.5%)
Anxiety	1 (2.3%)	2 (4.7%)
Grief or bereavement issues	2 (4.7%)	0
Relationship problems	1 (2.3%)	5 (11.6%)
Sleep disturbances	1 (2.3%)	2 (4.7%)
Eating problems	0	1 (2%)

had sought some medical or mental health treatment at the VA in the past 6 months (16.3% of all transvets). For the remaining participants, 7 stated they had not used any care in the past 6 months, 5 indicated the VA was not as easy to use, 1 expressed concern about discrimination at the VA, and 3 participants gave no response.

Barriers to General Health Care Utilization

Barriers to medical and mental health care endorsed by at least 10% of the transvets on the SUBS are presented in Table 4. The most common general barrier reported was the cost of health services, followed by knowing someone who had a bad experience with health services. Barriers that were endorsed more frequently for medical services than for mental health services included being worried about medical providers' reactions to their gender identity ($z = 1.91$, CI = 97%) or sexual orientation ($z = 1.68$, CI = 95%) as compared with mental health providers' reactions to these characteristics.

DISCUSSION

This study contributes to the field by examining rates of veteran status, health care utilization, and health in a community sample of MtF transgender individuals. Results indicated that 30% of the participants had prior military service, a rate that is triple the rate of veteran status in the general population (10.1%; U.S. Census Bureau, 2011). Of note, the majority of transvets were insured (95%) and sought regular health care in the past year (88.4%). Although survey methodology has many limitations, including undetermined generalizability, the high rate of veteran status among transgender individuals in the present study supports prior anecdotal reports and theoretical conceptualizations (e.g., Brown, 1988; Brown & Rounsley, 1996; Devor, 2004; McDuffie & Brown, 2010; TAVA, 2008). To our knowledge, this is the first examination of the rate of veteran status among a community MtF transgender sample.

The majority of transvets in this sample ($n = 36$) did not use the VA system in the past 6 months, with only about half of the transvets believing that they were eligible for VA care ($n = 23$). However, 9.3% reported primarily

TABLE 4. Health Care Barriers Reported by at Least 10% of Transgender Veterans

SUBS Item	Endorsed for medical services *n* (%)	Endorsed for mental health services *n* (%)
Health services costs too much.	18 (42%)	13 (30%)
Somebody I know or heard about had a bad experience with health services.	13 (30%)	8 (19%)
I would be afraid of the reaction of a doctor or counselor to my sexual orientation.*	9 (21%)	3 (7%)
I would be afraid of the reaction of a doctor or counselor to my gender identity.*	8 (19%)	3 (7%)
I would be seen as less competent as a person.	8 (19%)	7 (16%)
People would avoid me.	8 (19%)	5 (12%)
I would be seen as fundamentally flawed.	7 (16%)	6 (14%)
I don't like to talk in groups.	7 (16%)	6 (14%)
People would make fun of me.	7 (16%)	5 (12%)
People would see me as weak.	6 (14%)	6 (14%)
I would be less accepted by my friends.	6 (14%)	6 (14%)
I would be less accepted by my family.	6 (14%)	6 (14%)
I don't want a health problem to enter into my medical record.	6 (14%)	5 (12%)
People wouldn't trust me.	5 (12%)	5 (12%)
I've had a bad experience with health services before.	5 (12%)	3 (7%)
I don't like to talk about my personal life with other people.	5 (12%)	3 (7%)
It would be difficult to find the time for health services due to other commitments (i.e., work, family, friends, etc.).	5 (12%)	2 (5%)
People would see me as more likely to be violent or dangerous.	4 (9%)	5 (12%)
Health services are for people who have worse problems than I do.	4 (9%)	5 (12%)

*$p \leq .05$ one-tailed test of differences.

using VA services and 16.3% had sought some VA services in the past 6 months (30% of those who believed they were eligible for VA care). These rates are substantially higher than annual VA use among veterans in the general population (6.2% to 15.8% depending on extent of use assessed). These findings are striking given the truncated timeframe assessed (6 months rather than 1 year) and that only about half believed they were eligible for care. Reasons for not using VA services included believing they were not eligible ($n = 11$), being unsure about eligibility ($n = 9$), not using any care ($n = 7$), and the VA not being easy to use ($n = 5$). Only one transvet in this sample cited fear of discrimination as a barrier to VA use. However, in the earlier survey of transvets conducted by TAVA (2008), some discriminatory behavior was reported from VA doctors (22%), nonmedical staff (21%), and nurses (13%). Examples of the negative experiences transvets encountered included staff refusing to use gender-appropriate pronouns and being dismissive or denying general medical care to transgender individuals. Therefore, training of VA staff in appropriate transgender sensitivity could help assure culturally appropriate care for this minority group.

The current findings indicate that transvets are more likely to access care from the VA compared with veterans in the general population, and these rates could potentially increase following the new policy assuring access to care (Department of Veterans' Affairs, 2011). In addition, if trends in the general veteran population translate to this group, it would suggest that transvets would be more likely to seek services at the VA as they age and retire. In the general population, veterans who use VA services tend to be older, ethnic-minority veterans, with chronic health conditions, who are not employed (Long et al., 2005; Nelson et al., 2007). Thus, a more racially and educationally diverse sample of transgender persons that included individuals without health insurance and the resources to attend a national conference might have revealed an even higher rate of VA use based on predictors of VA use nationwide.

Irrespective of VA use, transvets in this study reported regular medical care utilization and physical health composite scores that were comparable with those of the general population. This finding is striking considering the multiple barriers that transgender individuals must overcome to receive health care. Indeed, more barriers to medical care were reported than for mental health care, which has clear implications for VA training medical staff, particularly as changes in access to care include the provision of hormone treatment and medical care subsequent to sex reassignment surgery (Department of Veterans Affairs, 2011). Given the variety of medical issues for which transvets are already seeking care at the VA (see Table 2) and the recent changes in access to VA, medical providers at the VA will need training in culturally appropriate care.

In terms of barriers to care, the most frequently endorsed barriers in this sample of transvets were the high cost of services or knowing someone who has had bad experiences with health services. Additionally, fear of providers' reactions to sexual orientation and/or gender identity were endorsed more frequently for medical services (sexual orientation, 21%; gender identity, 19%) than mental health services (both sexual orientation and gender identity, 7%), thus underscoring the importance of training for medical staff at both VA and non-VA facilities.

Overall, both veteran and nonveteran participants in this study had poorer mental health functioning than what is observed in the general population. This finding was somewhat unexpected given that a prior study of 188 transgender individuals failed to find differences from general population norms on measures of personality, sexual functioning, and psychological distress, with the exception of higher scores on the Openness to Experiences Subscale of the Neuroticism Extroversion Openness Personality Inventory (Brown et al., 1996). There are several possible reasons for this finding including that the SF-12 measure of mental health functioning may not be reliable with this population. Other reasons could include that the measure is reflecting distress due to high levels of stigma, discrimination, and/or transgender-related violence, which may each contribute to mental

health symptom elevation, particularly depression and posttraumatic stress disorder (e.g., Shipherd et al., 2010).

As reflected in Tables 1 and 3, about one third of transvets in this study reported seeking VA or non-VA mental health services for a variety of mental health conditions including gender identity counseling, relationship problems, and depression. It is not surprising that transvets were more likely to seek gender identity counseling outside the VA, given that historically, more gender identity specialists have been community based. However, coupled with poorer mental health functioning reported in this sample, it is clear that there are still unmet needs in this population. As such, transgender-specific program development and training in cultural competence are salient for all providers in the VA (Maguen et al., 2005; Mizock & Lewis, 2008; Shipherd et al., 2010), particularly given the recent VA policy, which includes the provision of mental health care and preoperative evaluations (Department of Veterans Affairs, 2011). Training and provider awareness will be central features of education initiatives, given the elevated rates of suicide (Maguen & Shipherd, 2010), risk for HIV infection (Kenagy & Hsieh, 2005), exposure to trauma (Shipherd et al., 2011), and other health challenges in the transgender population. Mental and medical health services are potential points of intervention with transvets at risk, and properly trained and bias-free professionals are crucial in this endeavor. Future research should continue to examine potential barriers to service utilization in the VA and non-VA systems, with a goal of minimizing barriers and improving service access and utilization.

Several limitations in the present study should be taken into account when interpreting these data. The use of self-report measures may have biased the accuracy of information participants offered. In addition, the convenience sample is one segment of the heterogeneous transgender population in the United States. However, given the paucity of research on the demographics of the U.S. transgender population, it is difficult to ascertain the generalizability of this sample. Although this is a limitation, most research conducted with the transgender population relies on convenience samples due to the difficulty with identifying transgender participants (TAVA, 2008). Locating a larger sample is relatively difficult due to the stigma associated with open identification of transgender identity, particularly in military and veteran populations. Additionally, the cross-sectional nature of this study is a limitation, as is the fact that these individuals are part of a visible transgender community who openly disclosed their transgender identity.

A further limitation of the current study is that the sample of transvets had high rates of good physical health, educational attainment, and health insurance coverage, the latter likely due to the Massachusetts health insurance laws. It is possible that there is a higher need for VA services in other states that do not require residents to be insured. Given the financial barriers associated with higher rates of unemployment, lower educational attainment, and racial minority status, transvets generally may be more likely to utilize VA health care benefits than they were in the current sample (Ashton et al., 1998), and rates of VA use by transvets were higher in this sample than in the general population. Finally, these data were gathered from a U.S. sample of transvets, and it is unclear if these data are generalizable to other countries and their armed forces personnel.

Implications for Behavioral Health

Despite these limitations, this research provides important information for the clinical care of transgender veterans. Given the elevated rates of transvets in this community sample, culturally sensitive treatment should be ensured for transvets in both VA and non-VA health care systems. Culturally sensitive transgender care is essential to improving health care utilization among these veterans by reducing negative encounters with providers in the health care setting. There is a need for VA staff training on transgender awareness and sensitivity to promote provision of culturally competent services. A national VA training subsequent to the recent transgender care policy is currently in the planning

stages. Anecdotally, cultural-competence training that occurred at the Boston VA following the implementation of a local policy assuring access to care in 2007 (VA Boston Healthcare System, 2007) improved provider confidence and sensitivity in treating transvets. High rates of veteran status among transgender individuals coupled with higher proportions of transvets using the VA (relative to the general population) suggest that transvet care is relevant to the VA. Even though a minority of transvets used VA services, they were already using the VA more than veterans generally. This trend is likely to increase given improved access to VA and may be magnified in samples with lower income, no insurance, and/or greater medical needs. One possibility is that veterans who do not use preventive health care services may present to the VA later with more costly, advanced, and complicated problems. Early intervention and outreach for preventive care would reduce future cost and increase satisfaction with VA services among transgender veterans.

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